FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041509

Facility Name: Heritage Manor-Carlinville

Address: 1200 UNIVERSITY AVENUE (Number) Carlinville (City) 61938 (Zip Code)

County: MACOUPIN

Telephone Number: (217) 854-4433 **Fax #** ( )

IDPA ID Number: 370909086006

Date of Initial License for Current Owners: 03/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Craig L. Ater
(Title) Senior V.P. & CFO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	85	Skilled (SNF)	85	31,025	1
2		Skilled Pediatric (SNF/PED)			2
3	23	Intermediate (ICF)	23	8,395	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,606	4,897	3,416	24,919	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	3,816	0	3,816	12
13	DD 16 OR LESS					13
14	TOTALS	16,606	8,713	3,416	28,735	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.89%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 03/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 3,416

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	129,916	7,709		137,625		137,625	2,788	140,413			1
2	Food Purchase		123,079		123,079		123,079		123,079			2
3	Housekeeping	63,910	17,013		80,923		80,923		80,923			3
4	Laundry	38,343	13,724		52,067		52,067		52,067			4
5	Heat and Other Utilities			84,572	84,572		84,572	1,236	85,808			5
6	Maintenance	45,767	46,112	18,327	110,206		110,206	12,407	122,613			6
7	Other (specify):*											7
8	**TOTAL General Services**	277,936	207,637	102,899	588,472		588,472	16,431	604,903			8
	B. Health Care and Programs											
9	Medical Director			3,625	3,625		3,625		3,625			9
10	Nursing and Medical Records	1,119,605	49,226	12,510	1,181,341		1,181,341		1,181,341			10
10a	Therapy		248,734	220,355	469,089	(506,493)	(37,404)	237,049	199,645			10a
11	Activities	53,584	1,484		55,068		55,068		55,068			11
12	Social Services	23,941		3,370	27,311		27,311		27,311			12
13	Nurse Aide Training	2,952	2,314		5,266		5,266	1,917	7,183			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,200,082	301,758	239,860	1,741,700	(506,493)	1,235,207	238,966	1,474,173			16
	C. General Administration											
17	Administrative	55,990			55,990		55,990	76,880	132,870			17
18	Directors Fees							6,973	6,973			18
19	Professional Services			219,445	219,445		219,445	(207,700)	11,745			19
20	Dues, Fees, Subscriptions & Promotions			78,623	78,623	(59,130)	19,493	(9,274)	10,219			20
21	Clerical & General Office Expenses	68,497	5,844	17,304	91,645		91,645	217,662	309,307			21
22	Employee Benefits & Payroll Taxes			302,500	302,500		302,500	31,216	333,716			22
23	Inservice Training & Education			757	757		757	844	1,601			23
24	Travel and Seminar			6,085	6,085		6,085	(4,086)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,170	52,170		52,170	2,152	54,322			26
27	Other (specify):*			17,016	17,016		17,016	(17,000)	16			27
28	**TOTAL General Administration**	124,487	5,844	693,900	824,231	(59,130)	765,101	97,667	862,768			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,602,505	515,239	1,036,659	3,154,403	(565,623)	2,588,780	353,064	2,941,844			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor-Carlinville #0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			113,347	113,347		113,347	10,725	124,072			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			132,309	132,309		132,309	8,784	141,093			32
33	Real Estate Taxes			38,496	38,496		38,496		38,496			33
34	Rent-Facility & Grounds							7,167	7,167			34
35	Rent-Equipment & Vehicles			3,969	3,969		3,969	10,763	14,732			35
36	Other (specify):*											36
37	**TOTAL Ownership**			288,121	288,121		288,121	37,439	325,560			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					506,493	506,493		506,493			39
40	Barber and Beauty Shops	8,432	443	32	8,907		8,907		8,907			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					59,130	59,130		59,130			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	8,432	443	32	8,907	565,623	574,530		574,530			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,610,937	515,682	1,324,812	3,451,431		3,451,431	390,503	3,841,934			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(696)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,110)	20		17
18	Fines and Penalties				18
19	Entertainment	(10,155)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,621)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,000)	27		24
25	Fund Raising, Advertising and Promotional	(11,893)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,475)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	432,978		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 432,978		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 390,503		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heritage Manor-Carlinville

ID# 0041509

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(1,110)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,621)	19	22
23				23
24		(17,000)	27	24
25		(11,893)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(31,624)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	2,788	0	0	0	0	0	0	0	0	2,788	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,236	0	0	0	0	0	0	0	0	1,236	5
6	Maintenance	0	0	12,407	0	0	0	0	0	0	0	0	12,407	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	16,431	0	0	0	0	0	0	0	0	16,431	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	237,049	0	0	0	0	0	0	0	0	0	237,049	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,917	0	0	0	0	0	0	0	0	1,917	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	237,049	1,917	0	0	0	0	0	0	0	0	238,966	16
	C. General Administration													
17	Administrative	0	0	76,880	0	0	0	0	0	0	0	0	76,880	17
18	Directors Fees	0	0	6,973	0	0	0	0	0	0	0	0	6,973	18
19	Professional Services	(1,621)	(217,824)	11,745	0	0	0	0	0	0	0	0	(207,700)	19
20	Fees, Subscriptions & Promotions	(13,003)	0	3,729	0	0	0	0	0	0	0	0	(9,274)	20
21	Clerical & General Office Expenses	0	0	217,662	0	0	0	0	0	0	0	0	217,662	21
22	Employee Benefits & Payroll Taxes	0	0	31,216	0	0	0	0	0	0	0	0	31,216	22
23	Inservice Training & Education	0	0	844	0	0	0	0	0	0	0	0	844	23
24	Travel and Seminar	(10,155)	0	6,069	0	0	0	0	0	0	0	0	(4,086)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,152	0	0	0	0	0	0	0	0	2,152	26
27	Other (specify):*	(17,000)	0	0	0	0	0	0	0	0	0	0	(17,000)	27
28	**TOTAL General Administration**	(41,779)	(217,824)	357,270	0	0	0	0	0	0	0	0	97,667	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,779)	19,225	375,618	0	0	0	0	0	0	0	0	353,064	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	10,725	0	0	0	0	0	0	0	10,725	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(696)	0	0	9,480	0	0	0	0	0	0	0	8,784	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	7,167	0	0	0	0	0	0	0	7,167	34
35	Rent-Equipment & Vehicles	0	0	0	10,763	0	0	0	0	0	0	0	10,763	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(696)	0	0	38,135	0	0	0	0	0	0	0	37,439	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(42,475)	19,225	375,618	38,135	0	0	0	0	0	0	0	390,503	45

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization	136,052	GreenTree Therapy	100.00%	124,556	(11,496)	2
3	V								3
4	V	19	Adjustment for Related Organization	217,824	Heritage Enterprises, Inc.	100.00%		(217,824)	4
5	V								5
6	V	10a	Adjustment for Related Organization	247,416	GreenTree Pharmacy	100.00%	495,961	248,545	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 601,292			$ 620,517	$ * 19,225	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 2,788	$ 2,788	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				0		17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,236	1,236	19
20	V	6	Maintenance				12,407	12,407	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,917	1,917	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				76,880	76,880	29
30	V	18	Directors Fees				6,973	6,973	30
31	V	19	Professional Services				11,745	11,745	31
32	V	20	Fees, Subscription, Promotions				3,729	3,729	32
33	V	21	Clerical & General Office Expenses				217,662	217,662	33
34	V	22	Employee Benefits & Payroll Taxes				31,216	31,216	34
35	V	23	Inservice Training & Education				844	844	35
36	V	24	Travel and Seminar				6,069	6,069	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				2,152	2,152	38
39	Total			$			$ 375,618	$ * 375,618	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15
16	V	30	Depreciation				10,725	10,725	16
17	V	31	Amortization of Pre-Op & Org				0		17
18	V	32	Interest				9,480	9,480	18
19	V	33	Real Estate Taxes				0		19
20	V	34	Rent-Facility & Grounds				7,167	7,167	20
21	V	35	Rent-Equipment & Vehicles				10,763	10,763	21
22	V	36	Other				0		22
23	V	38	Medically Nec Transportation				0		23
24	V	39	Ancillary Service Centers				0		24
25	V	40	Barber and Beauty Shops				0		25
26	V	41	Coffee and Gift Shops				0		26
27	V	42	Other				0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 38,135	$ * 38,135	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bill Froelich	Director	Management	26.00	320,135	5	100.00	Director/Salar	$ 14,389	line 17/18, col	1
2	Tom Jefferson	Secretary	Management	10.00	385,686	5	100.00	Director/Salary	17,334	line 17/18, col	2
3	Craig Hart	Chairman	Management	20.00	372,740	10	100.00	Director/Salary	16,752	line 17/18, col	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.30	222,499	40	100.00	Director/Salary	10,000	line 17/18, col	4
5	Steve Wannemacher	President	Management	0.30	251,231	40	100.00	Director/Salary	11,291	line 17/18, col	5
6	Connie Hoselton	Sr Vice President	Management	0.20	148,865	40	100.00	Salary	6,691	line 17, col 7	6
7	Craig Ater	Sr Vice President	Management	0.20	164,565	40	100.00	Salary	7,396	line 17, col 7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 83,853		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,403	24	$ 62,023	$ 62,023	108	$ 2,788	1
2	2	Food Purchase	Beds	2,403	24	0	0	108	0	2
3	3	Housekeeping	Beds	2,403	24	0	0	108	0	3
4	4	Laundry	Beds	2,403	24	0	0	108	0	4
5	5	Heat & Other Utilities	Beds	2,403	24	27,509	0	108	1,236	5
6	6	Maintenance	Beds	2,403	24	276,052	67,064	108	12,407	6
7	7	Other	Beds	2,403	24	0	0	108	0	7
8	9	Medical Director	Beds	2,403	24	0	0	108	0	8
9	10	Nursing & Medical Records	Beds	2,403	24	0	0	108	0	9
10	11	Activities	Beds	2,403	24	0	0	108	0	10
11	12	Social Service	Beds	2,403	24	0	0	108	0	11
12	13	Nurse Aide Training	Beds	2,403	24	42,658	42,572	108	1,917	12
13	14	Program Transportation	Beds	2,403	24	0	0	108	0	13
14	15	Other	Beds	2,403	24	0	0	108	0	14
15	17	Administrative	Beds	2,403	24	1,710,580	0	108	76,880	15
16	18	Directors Fees	Beds	2,403	24	155,144	0	108	6,973	16
17	19	Professional Services	Beds	2,403	24	261,316	0	108	11,745	17
18	20	Fees, Subscription, Promotions	Beds	2,403	24	82,980	0	108	3,729	18
19	21	Clerical & General Office Expens	Beds	2,403	24	4,842,980	4,501,882	108	217,662	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,403	24	694,554	0	108	31,216	20
21	23	Inservice Training & Education	Beds	2,403	24	18,789	0	108	844	21
22	24	Travel and Seminar	Beds	2,403	24	135,033	0	108	6,069	22
23	25	Other Admin. Staff Transportatio	Beds	2,403	24	0	0	108	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,403	24	47,877	0	108	2,152	24
25	TOTALS					$ 8,357,495	$ 4,673,541		$ 375,618	25

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,403	24	$	$	108	$	1
2	30	Depreciation	Beds	2,403	24	238,628		108	10,725	2
3	31	Amortization of Pre-Op & Org	Beds	2,403	24			108		3
4	32	Interest	Beds	2,403	24	210,931		108	9,480	4
5	33	Real Estate Taxes	Beds	2,403	24			108		5
6	34	Rent-Facility & Grounds	Beds	2,403	24	159,466		108	7,167	6
7	35	Rent-Equipment & Vehicles	Beds	2,403	24	239,478		108	10,763	7
8	36	Other	Beds	2,403	24			108		8
9	38	Medically Nec Transportation	Beds	2,403	24			108		9
10	39	Ancillary Service Centers	Beds	2,403	24			108		10
11	40	Barber and Beauty Shops	Beds	2,403	24			108		11
12	41	Coffee and Gift Shops	Beds	2,403	24			108		12
13	42	Other	Beds	2,403	24			108		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 848,503	$		$ 38,135	25

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City		XX	Mortage	$28,143.00	03/01/96	$ 3,385,859	$ 2,481,888	01/15/06	variable	$ 108,327	1
2	National City Loan Amortization		XX	Mortgage							6,060	2
3	Central Office Allocation		XX	Interest Income								3
4	Alpha Community Bank		xx			05/01/01	93,753	56,254	05/01/06	variable	2,812	4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital							15,110	6
7	Central Office Allocation		xx	Working Capital							9,480	7
8												8
9	TOTAL Facility Related				$28,143.00		$ 3,479,612	$ 2,538,142			$ 141,789	9
	B. Non-Facility Related*											
10	Interest Income										(696)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (696)	14
15	TOTALS (line 9+line14)						$ 3,479,612	$ 2,538,142			$ 141,093	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 35,368	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 36,030	2
3. Under or (over) accrual (line 2 minus line 1).		$ 662	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,834	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 38,496	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Carlinville COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 0041509

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1200026402	Heritage Manor-Carlinville	$ 36,031.00	$ 36,031.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,031.00	$ 36,031.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 32,017	1
2					2
3	TOTALS			$ 32,017	3

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	82				$ 3,265,145	$		$	$	$	4
5	24										5
6	5										6
7											7
8											8
	Improvement Type**										
9	Heritage Manor Sign			1996	2,176						9
10	Architect Fees			1996	2,387						10
11	Laundry Room Electrical Repair			1996	3,019						11
12											12
13											13
14	Special Care Unit -- Remodel			1997	30,884						14
15											15
16	Remodel-- Alzheimer Wing			1998	78,813						16
17	A/C Unit			1998	950						17
18	Life Safety Improvements			1998	7,351						18
19	Shower Room Remodel			1998	2,811						19
20	Roof Replacement			1998	92,246						20
21											21
22	Door Alarm			1999	2,317						22
23	Smoke Damperer			1999	498						23
24	Water System			1999	8,115						24
25	Interior Painting--Material and Labor			1999	6,892						25
26	Shower Room Remodel			1999	2,453						26
27	Water Heater			1999	4,253						27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							10,725	10,725		34
35	Book Depreciation					92,391		92,391		678,881	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Softener	2000	$ 3,802	$		$	$	$	37
38	Shower room Remodel ---Material and Labor	2000	3,608						38
39	A/C Rooftop Unit	2000	12,490						39
40	Pipe --Hallway Floor	2000	1,920						40
41									41
42	Electric Heater	2001	4,700						42
43									43
44	A/C Rooftop Unit-(remove)	2002	(12,490)						44
45	Heat / Cool Unit	2002	8,969						45
46	Floor Coverings	2002	6,638						46
47	Roof top unit	2002	4,995						47
48	Roof top unit	2002	2,918						48
49									49
50	Floor coverings	2003	11,232						50
51	Resurface parking lot	2003	25,786						51
52	A/C unit	2003	11,167						52
53	Dishwasher	2003	3,880						53
54	Boiler	2003	1,978						54
55	Backflow unit	2003	740						55
56	Heat / Cool Unit	2003	5,607						56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,608,250	$ 92,391		$ 103,116	$ 10,725	$ 678,881	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,608,250	$ 92,391		$ 103,116	$ 10,725	$ 678,881	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,608,250	$ 92,391		$ 103,116	$ 10,725	$ 678,881	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 368,070	$ 20,956	$ 20,956	$		$ 330,721	71
72	Current Year Purchases	11,619						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 379,689	$ 20,956	$ 20,956	$		$ 330,721	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,019,956	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 113,347	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 124,072	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,725	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,009,602	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 14,732 Description: pager, computer equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		2,314		2,314
3	Classroom Wages (a)		2,952		2,952
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 5,266	$	$ 5,266
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,266			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 81,452	$		$ 81,452	1
2	Licensed Speech and Language Development Therapist		hrs			29,344			29,344	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			87,531	1,318		88,849	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				495,961		495,961	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					10,532			10,532	13
14	TOTAL			$		$ 208,859	$ 497,279		$ 706,138	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Manor-Carlinville **#** 0041509 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,832	$	1
2	Cash-Patient Deposits	7,420		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	402,898		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,459		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,590,541)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,161,932)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,017		13
14	Buildings, at Historical Cost	3,608,250		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	379,689		16
17	Accumulated Depreciation (book methods)	(1,009,601)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	20,871		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,031,226	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,869,294	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 70,979	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,420		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	172,582		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,619		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,834		32
33	Accrued Interest Payable	10,858		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Escrow			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 302,292	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,538,142		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,538,142	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,840,434	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (971,140)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,869,294	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,029,589)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,029,589)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	58,449	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 58,449	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (971,140)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,425,653	1
2	Discounts and Allowances for all Levels	(777,105)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,648,548	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	415,595	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 415,595	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,026	12
13	Barber and Beauty Care	12,510	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	430,450	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	55	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 445,041	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	696	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 696	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,509,880	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	588,472	31
32	Health Care	1,741,700	32
33	General Administration	824,231	33
	B. Capital Expense		
34	Ownership	288,121	34
	C. Ancillary Expense		
35	Special Cost Centers	8,907	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,451,431	40
41	**Income before Income Taxes (line 30 minus line 40)****	58,449	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 58,449	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,747	1,950	$ 41,341	$ 21.20	1
2	Assistant Director of Nursing	1,254	1,490	20,770	13.94	2
3	Registered Nurses	3,183	3,246	63,735	19.63	3
4	Licensed Practical Nurses	15,362	16,155	279,503	17.30	4
5	Nurse Aides & Orderlies	70,498	74,713	713,012	9.54	5
6	Nurse Aide Trainees	400	400	2,952	7.38	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	28	94	1,244	13.23	8
9	Activity Director					9
10	Activity Assistants	6,232	6,719	53,584	7.97	10
11	Social Service Workers	1,798	2,042	23,941	11.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,960	16,811	129,916	7.73	15
16	Dishwashers					16
17	Maintenance Workers	3,660	3,996	45,767	11.45	17
18	Housekeepers	11,404	11,604	63,910	5.51	18
19	Laundry	3,465	3,843	38,343	9.98	19
20	Administrator	2,080	2,080	55,990	26.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,033	5,621	68,497	12.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,000	1,000	8,432	8.43	33
34	TOTAL (lines 1 - 33)	143,104	151,764	$ 1,610,937 *	$ 10.61	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		3,625		36
37	Medical Records Consultant		697		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,166		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,370		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,858		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barb Re	Admin	0	$ 55,990
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,990

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 217,824
		0
		0
		0
Legal Fees (Adjusted to zero)		1,621
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 219,445

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,163
Unemployment Compensation Insurance	15,559
FICA Taxes	123,237
Employee Health Insurance	121,609
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	10,932
Employee Benefits - central office	31,216
TOTAL (agree to Schedule V, line 22, col.8)	$ 333,716

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	506
Health Care Worker Background Check	
(Indicate # of checks performed)	371
Central Office Allocation	3,729
Promotional Advertising	4,546
Public Relations	7,347
Dues and Subscriptions	6,423
License and Fees	300
Less: Public Relations Expense	(7,347)
Non-allowable advertising	(1,110)
Yellow page advertising	(4,546)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,219

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,271
	154
Seminar Expense	1,660
Non Allowable	(10,155)
Central Office Allocation	6,069
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heritage Manor-Carlinville **#** 0041509 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,130**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **177**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Pellman & Dold** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. **Not Complete as of this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount				
1009			PETTY CASH	3,832							1,009	1,009 PETTY CA	3,832
1010			CASH IN BANK								1,100	1,100 ACCTS RE	402,898
1040			CASH IN BANK-PAYROLL								1,101	1,101 ALLOW. FOR UNCOLLECTIBLES	
1100			ACCOUNTS RECEIVABLE	402,898							1,110	1,110 ACCTS RECEIV-M/C	
1110			MEDICARE RECEIVABLES								1,125	1,125 ACCTS RECEIV-IPA	
1125			IPA INCOME RECEIVABLE								1,135	1,135 ACCTS RECEIV-IC	
1130			MEDICARE COST REPORT								1,140	1,140 UNAPPLIED CASH RECEIPTS	
1135			ACCOUNTS RECEIVABLE-IC								1,145	1,145 A/R SUSPENSE-REFUNDS	
1140			UNAPPLIED CASH RECEIPTS								1,200	1,200 PREPAID I	14,459
1145			A/R SUSPENSE-REFUNDS								1,220	1,220 OTHER PREPAID EXPENSES	
1190			ACCRUED INTEREST REC								1,300	1,300 DIETARY INVENTORY	
1200			PREPAID INSURANCE	14,459							1,310	1,310 SUPPLIES INVENTORY	
1220			OTHER PREPAID EXPENSES								1,320	1,320 LINEN INVENTORY	
1300			FOOD INVENTORY								1,409	1,409 LAND	32,017
1310			SUPPLIES INVENTORY								1,450	1,450 FURNITUR	379,689
1409			LAND	32,017							1,460		-330,721
1450			FURNITURE & EQUIPMENT	379,689							1,475	1,475 CODE ALE	3,608,250
1460			ACCUM DEPR-FURN & EQUIP	-330,721							1,490	1,490 ACCUM D	-678,880
1475			BUILDING & IMPROVEMENTS	3,608,250							1,530	1,530 RESIDENT	7,420
1490			ACCUM DEPR-BUILDING	-678,880							1,550	1,550 LOAN FEE	20,870
1530			RESIDENT FUNDS	7,420							1,551	1,551 LOAN FEES ADDED	
1550			LOAN FEES	20,870							1,850	1,850 INTERCOM	-1,590,541
1560			REAL ESTATE TAX ESCROW								2,010	2,010 ACCOUNT	-70,979
1575			REIMBURSABLE PURCHASES								2,100	2,095 BONUSES PAYABLE	
1850			INTRACOMPANY	-1,590,541							2,100	2,100 ACCRUED	-91,951
2010			ACCOUNTS PAYABLE	-70,979							2,100	2,100 PR CLEARING-BENEFITS	
2095			BONUSES PAYABLE								2,100	2,100 PR CLEARING-LABOR	
2100			ACCRUED PAYROLL	-91,951							2,110	2,110 ACCRUED	-80,631
2110			ACCRUED VACATION PAY	-80,631							2,120	2,120 U.C. TAXES PAYABLE	
2120			UC TAXES PAYABLE								2,125	2,125 FICA TAXI	-2,619
2125			FICA TAX PAYABLE	-2,619	-2,619						2,130	2,130 FEDERAL W/H TAX PAYABLE	
2130			FIT PAYABLE								2,140	2,140 STATE W/H TAX PAYABLE	
2140			STATE W/H PAYABLE		0						2,152	2,152 WORKERS COMP ACCRUAL	
2145			EARNED INCOME CREDIT								2,225	2,225 EMPLOYEEE INSURANCE REFUND	
2150			UC FED CREDIT REDUCTION								2,230	2,230 PAYROLL SAVINGS	
2230			PAYROLL SAVINGS								2,235	2,240 UNITED FUND	
2235			IRA W/HOLDINGS								2,240	2,246 GROUP INSURANCE - CAFETERIA	
2240			UNITED WAY								2,246	2,250 401K W/H	
2245			GROUP INSURANCE PAYABLE								2,250		
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260	2,260 WAGE GARNISHMENT	
2260			WAGE GARNISHMENTS								2,300	2,300 ACCRUED	-10,858
2280			MISC PAYROLL DEDUCTIONS								2,320	2,320 IPA PAYM	0
2300			ACCRUED INTEREST PAYABLE	-10,858							2,350	2,350 REAL EST.	-37,834
2310			SALES TAX PAYABLE								2,385		
2320			IPA PAYMENTS PAYABLE	0							2,400	2,400 CURRENT PORTION OF LT DEBT	
2350			REAL ESTATE TAX PAYABLE	-37,834							2,512	2,512 DUE TO RI	-7,420
2385			ACTIVITY FUND	0							2,600	2,600 LASALLE	-2,481,888
2390			SECURITY DEPOSITS								2,600		
2391			VOLUNTEER FUND								2,625	2,625 LASALLE	-56,254
2393			HEART FUND/BAZAAR								2,625		
2395			DEFERRED INC EMP & MEM								2,695	2,695 CURRENT PORTION OF LT DEBT	
2400			CURRENT PORTION LT DEBT								2,720	2,720 RETAINEE	1,029,590
2460			INCOME TAXES PAYABLE									net income	-58,449
2512			DUE TO RESIDENTS	-7,420									
2600			MORTGAGE PAYABLE	-2,538,142									
2650			EQUIPMENT LOAN PAYABLE									balance	0
2695			CURRENT PORTION LT DEBT										
2696			DEFERRED INCOME TAXES										
2710			COMMON STOCK										
2720			RETAINED EARNINGS	1,029,590									
2970			PROFIT/LOSS FOR PERIOD	-58,449									
3007.1			PATIENT DAYS-PRIVATE	8,846							3,007	3,007 PATIENT I	8,846
3007.2			PATIENT DAYS-IPA	16,606							3,007	3,007 PATIENT I	16,606
3007.3			PATIENT DAYS-MEDICARE	3,416							3,007	3,007 PATIENT I	3,416
3007.4			PATIENT DAYS-CONVERSION								3,007		
3007.5			PATIENT DAYS-LICENSED								3,007		
3007.6			PATIENT DAYS-TOTAL								3,007		
3010		1	BASIC CHARGE-PRIVATE & VA	-924,764		0	0	0	0		3,007		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		3,010	3,010 BASIC CH.	(924,764)
3020		1	BASIC CHARGE-IPA	-1,306,355		0	0	0	0		3,020	3,020 BASIC CH.	(1,306,355)
3030		1	BASIC CHARGE-MEDICARE	-918,546		0	0	0	0		3,030	3,030 BASIC CH.	(918,546)
3035		4	DAY CARE/HOME CARE			0	0	0	0		3,040	3,040 LIGHT NU	(3,724)
3040		1	LIGHT NURSING CARE	-78,442		0	0	0	0		3,050	3,050 MEDIUM N	(19,184)
3050		1	MEDIUM NURSING CARE			0	0	0	0		3,060	3,060 HEAVY NU	(45,356)
3060		1	HEAVY NURSING CARE			0	0	0	0		3,061	3,061 SKILLED N	(10,178)
3061		1	SKILLED NURSING CARE								3,080	3,080 NURSING	(29,190)
3080		1	NURSING SUPPLIES-PRIVATE	-161,676		0	0	0	0		3,081	3,081 NURSING	(85,786)
3081		1	NURSING SUPPLIES-IPA			0	0	0	0		3,082	3,082 NURSING	(39,651)
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0		3,083	3,083 NURSING	(7,049)
3083		1	NURSING SUPPLIES MED PT B								3,100	3,100 DRUGS-MI	(225,468)
3100		17	DRUGS	-430,450		0	0	0	0		3,101	3,101 DRUGS-OT	(204,982)
3101		17	DRUGS-OTHER								3,110	3,110 PHYSICAL	(2,210)
3110		6	PT-PRIVATE	-415,595		0	0	0	0		3,111	3,111 PHYSICAL	(200)
3111		6	PT-IPA			0	0	0	0		3,112	3,112 PHYSICAL	(127,320)
3112		6	PT-MEDICARE PART A			0	0	0	0		3,113	3,113 PHYSICAL	(48,754)
3113		6	PT-MEDICARE PART B			0	0	0	0		3,140	3,140 LABORAT	(6,428)
3130		1	PUBLIC AID ASSESSMENT INC								3,150	3,150 ST/OT THE	(2,230)
3140		19	LABORATORY INCOME			0	0	0	0		3,151	3,151 ST/OT THE	(270)
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		3,152	3,152 ST/OT THE	(172,640)
3151		6	SPEECH/OT-IPA			0	0	0	0		3,153	3,153 ST/OT THE	(49,859)
3152		6	SPEECH/OT-MED PART A			0	0	0	0		3,160	3,185 REHAB/ISC	(5,684)
3153		6	SPEECH/OT MED PART B								3,410	3,410 IPA/OTHEI	175,419
3410		2	IPA DISCOUNTS	777,105		0	0	0	0		3,411	3,411 MEDICARI	23,886
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0		3,420	3,420 MEDICARI	568,340
3420		2	MEDICARE DISCOUNTS			0	0	0	0		3,500		
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0		3,520		
3520		16	RENT INCOME	0		6	0	6	0		3,530	3,530 BEAUTY S	(12,510)
3530		13	BEAUTY SHOP	-12,510		0	0	0	0		3,560	3,560 ACTIVITY	(370)
3560		12	ACTIVITY FUND INCOME	-370		0	0	0	0		3,570	3,570 VENDING	(1,656)
3570		12	VENDING INCOME/EXPENSE	-1,656		0	0	0	0		3,590	3,590 EQUIPMEN	(35,870)
3580		12	MANAGEMENT FEES			0	0	0	0		3,595		
3590		1	EQUIPMENT RENTAL	-35,870		0	0	0	0		3,600	3,600 MISC INCO	(55)
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0		4,110	4,110 G&A WAG	64,408
3600		21	MISC INCOME	-55		0	0	0	0		4,111	4,111 ADMINIST	55,990
4110			GENERAL & ADMINIST WAGES	64,408	68,497	21	1	17	0		4,115	4,115 G&A PTO	4,089
4111			ADMINISTRATOR WAGES	55,990	55,990	17	1	0	0		4,120	4,120 EMPLOYE	9,702
4115			VACATION & SICK - G&A	4,089		21	1	0	0		4,125		
4120	4475		EMPLOYEE BENEFITS	10,932	302,500	22	3	0	0		4,130		
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0		4,135		
4130			EMPLOYEE SCHOLORSHIP WA	0		21	1	0	0		4,250	4,250 OFFICE SU	3,610
4135			EMPLOYEE SCHOLORSHIP COS	0		23	3	0	0		4,255	4,255 POSTAGE	1,406
4220			DIRECTORS FEES			18	3	0	0		4,260	4,260 TELEPHON	17,304
4250	4255		OFFICE SUPPLIES	5,844	5,844	21	2	0	0		4,275	4,275 TRAINING	757
4260			TELEPHONE	17,304	17,304	21	3	0	0		4,276	4,276 INJURY PR	(90)
4275			TRAINING & EMPLOYEE DEVL	757	757	23	3	16	0		4,280	4,280 GENERAL	4,271
4280			GENERAL TRAVEL	4,271	6,085	24	3	16	0		4,281	4,281 MEAL EXP	154
4281			MEAL EXPENSE FOR TRAVEL	154		24	3	19	0		4,285	4,285 EDUCATIO	1,660
4285			EDUCATION & SEMINAR	1,660		24	3	19	-10,155 ***		4,289		
4290			HELP WANTED ADVERTISING	506	78,623	20	3	0	0	-59,130	4,290	4,290 HELP WAN	506
4291			PROMOTIONAL ADVERTISING	4,546		20	3	25	-4,546		4,291	4,291 PROMOTIO	4,546
4292			PUBLIC RELATIONS	7,347		20	3	25	-7,347		4,292	4,292 PUBLIC RE	7,347
4300			LICENSES & FEES	59,430		20	3	17	0		4,300	4,300 LICENSE &	59,430
4310			DUES & SUBSCRIPTIONS	6,423		20	3	17	-1,110		4,310	4,310 DUES & SU	6,423
4320			CONTRIBUTIONS	0		27	3	20	0		4,320		
4350			PROFESSIONAL FEES	1,621	219,445	19	3	22	-1,621		4,350	4,350 PROFESSIO	1,621
4355			MEDICAL DIRECTOR	3,625	3,625	9	3	0	0		4,355	4,355 MEDICAL	3,625
4360			UTILIZATION REVIEW	3,750		10	3	0	0		4,362	4,362 MEDICAL	697
4361			OTHER PHYSICIAN FEES	4,800		39	3	0	0		4,363	4,363 PHARMAC	2,166
4362			MEDICAL RECORDS CONSULT	697		10	3	0	0		4,364	4,364 SOCIAL SE	3,370
4363			PHARMACIST FEES	2,166		10	3	0	0		4,370		
4364			SOC SERV/ACT CONSULT	3,370	3,370	12	3	0	0		4,383	4,383 BACKGRO	371
4370			TV RENTAL	0		35	3	5	0		4,390		
4380			INCOME TAXES		17,016	27	3	26	0		4,400	4,400 PAYROLL	133,206
4383			BACKGROUND CHECKS	371		20	3	26	0		4,401	4,401 PAYROLL	5,590
4400			PAYROLL TAXES	133,206		22	3	0	0		4,410	4,410 GROUP IN	121,609
4401			PAYROLL TAXES ADMINIST	5,590		22	3	0	0		4,420	4,420 LIABILITY	52,170
4410			GROUP INSURANCE	121,609		22	3	0	0		4,430	4,430 WORKMA	26,774
4420			LIABILITY INSURANCE	52,170	52,170	26	3	0	0		4,435	4,435 W/C-FIRST	3,660
4425			INSURANCE-OWNERS			22	3	21	0		4,436	4,436 DRUG TES	819
4430			WORKMENS COMP INSURANCE	31,163		22	3	0	0		4,450	4,450 CENTRAL	217,824
4450			CENTRAL OFFICE FEES	217,824		19	3	34	-217,824		4,460	4,460 BAD DEBT	17,000
4460			BAD DEBTS	17,000		27	3	24	-17,000		4,461	4,461 BAD DEBT	9,460
4470			LOST ITEMS-RESIDENTS	16		27	3	0			4,470	4,470 LOST ITEM	16
4490			MISCELLANEOUS	0		27	3	0	0		4,475	4,475 UNIFORM	1,230
4510			REAL ESTATE TAXES	38,496	38,496	33	3	0	0		4,486	4,486 SERVICE C	3,537
4600			LEASED EQUIPMENT	3,969	3,969	35	3	16	0		4,490	4,490 MISC EXPE	(733)
5110			MAINTENANCE SALARIES	42,795	45,767	6	1	0	0		4,496	4,496 MISC. M.I.	828
5120			MAINTENANCE SICK & VAC	2,972		6	1	0	0		4,510	4,510 REAL EST.	38,496
5130			ELECTRIC	44,962	84,572	5	3	0	0		4,600	4,600 LEASED E	3,969
5131			NATURAL GAS	10,749		5	3	0	0		5,110	5,110 MAINTENA	42,795
5132			HEATING & DEISEL OIL			5	3	0	0		5,120	5,120 MAINTENA	2,972
5133			WATER & SEWER	28,861		5	3	0	0		5,130	5,130 ELECTRIC	44,962
5134			TRASH COLLECTION	3,546	18,327	6	3	0	0		5,131	5,131 NATURAL	10,749
5140			PROPERTY PLANT REPLACEM	14,857	46,112	6	2	0	0		5,133	5,133 WATER &	28,861
5160			GENERAL REPAIR & MAINT	31,255		6	2	0	0		5,134	5,134 TRASH CC	3,546
5165			MAINTENANCE CONTRACTS	14,781		6	3	0	0		5,140	5,140 PROP/PLA	14,857
5210			DIETARY WAGES	123,621	129,916	1	1	0	0		5,160	5,160 GENERAL	31,255
5220			DIETARY SICK & VAC	6,295		1	1	0	0		5,165	5,165 MAINTENA	11,244
5240			SALES TAX			2	3	13	0		5,210	5,210 DIETARY	123,621
5248			FOOD PURCHASES	123,256	123,079	2	2	0	0		5,220	5,220 DIETARY	6,295
5250			SUPPLIES-DISHWASHING	3,337	7,709	1	2	0	0		5,248	5,248 FOOD PUR	123,989
5260			DIETARY REPLACEMENT	510		1	2	0	0		5,250	5,250 SUPPLIES	3,337
5270			KITCHEN SUPPLIES-PAPER	3,862		1	2	0	0		5,260	5,260 REPLACEM	510
5295			MEAL CREDIT	-177		2	2	0	0		5,270	5,270 KITCHEN	3,862
5310			LAUNDRY WAGES	34,952	38,343	4	1	0	0		5,295	5,295 MEAL INC	(177)
5340			LAUNDRY SICK & VAC	3,391		4	1	0	0		5,310	5,310 LAUNDRY	34,952
5370			LAUNDRY REPLACEMENT	6,942	13,724	4	2	0	0		5,340	5,340 LAUNDRY	3,391
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		5,370	5,370 REPLACEM	6,942
5390			LAUNDRY SUPPLIES	6,782		4	2	0	0		5,380	5,380 OUTSIDE I	22
5410			HOUSEKEEPING WAGES	61,678	63,910	3	1	0	0		5,390	5,390 SUPPLIES	6,760
5440			HOUSEKEEPING SICK & VAC	2,232		3	1	0	0		5,410	5,410 HOUSEKE	61,678
5480			HOUSEKEEPING SUPPLIES	0	17,013	3	2	0	0		5,440	5,440 HOUSEKE	2,232
5490			HOUSEKEEPING SUPPLIES-PPR	17,013		3	2	0	0		5,480		
6010			RN WAGES-MEDICARE		1,119,605	10	1	0	0		5,490	5,490 SUPPLIES-	17,013
6020			RN WAGES-NON MEDICARE	58,809		10	1	0	0		6,020	6,020 RN WAGE	58,809
6030			DON WAGES	41,341		10	1	0	0		6,030	6,030 DON WAG	41,341
6035			ADON	20,770		10	1	0	0		6,035	6,035 ADON WA	20,770
6040			RN SICK & VACATION	4,926		10	1	0	0		6,040	6,040 RN PTO &	4,926
6110			LPN WAGES-MEDICARE			10	1	0	0		6,120	6,120 LPN WAGI	264,173
6120			LPN WAGES-NON MEDICARE	264,173		10	1	0	0		6,140	6,140 LPN PTO &	15,330
6130			LPN WAGES OTHER			10	1	0	0		6,220	6,220 AIDES WA	658,083
6140			LPN SICK & VACATION	15,330		10	1	0	0		6,240	6,240 AIDES PTO	54,929
6210			AIDE WAGES-MEDICARE			10	1	0	0		6,245		
6220			AIDE WAGES-NON MEDICARE	658,083		10	1	0	0		6,246		
6230			WARD CLERKS			10	1	0	0		6,247		
6240			AIDE VACATION & SICK	54,929		10	1	0	0		6,250	6,250 NURSE AII	2,952
6245			CONTRACT NURSES-RN	0		10	3	0	0		6,255	6,255 NURSE AII	2,314
6246			CONTRACT NURSES-LPN	0		10	3	0	0		6,260		
6247			CONTRACT NURSES-AIDES	0		10	3	0	0		6,270	6,270 REHAB W.	1,351
6250			NURSE AIDE TRAINING WAGES	2,952	2,952	13	1	0	0		6,275	6,275 REHAB PT	(107)
6255			NURSE AID TRAINING EXP	2,314	2,314	13	2	0	0		6,290	6,290 NURSING	43,470
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0		6,295	6,295 NURSING	4,548
6270			REHAB WAGES	1,351		10	1	0	0		6,390	6,390 REPLACEM	1,208
6275			REHAB SICK & VAC	-107		10	1	0	0		6,490	6,490 OTHER	1,097
6280			NURSING DEPT EDUCATION			23	3	0	0		7,280	7,280 DRUG PUR	122,378
6290			NURSING SUPPLIES	43,470	49,226	10	2	0	0		7,281	7,281 DRUG PUR	125,038
6295			NURSING SUPPLIES	4,548		10	2	0	0		7,380	7,380 LABORAT	4,990
6390			REPLACEMENT-NURSING	1,208		10	2	0	0		7,391	7,390 X-RAY SEI	5,182
6490			NURSING OTHER	1,097	12,510	10	3	0	0		7,393	7,391 AMBULAN	360
7280			DRUG PURCHASES	122,378	248,734	39	2	0	248,545 ***		7,510	7,510 ACTIVITIE	50,983
7281			DRUG PURCHASES-OTHER	125,038		39	2				7,540	7,540 ACTIVITIE	2,601
7380			LABORATORY SERVICES	10,532	220,355	39	3	0	0		7,590	7,590 ACTIVITIE	1,484
7410			HOME HEALTH SALARY			39	1	0	0		7,620	7,620 PHYSICAL	98,406
7440			HOME HEALTH SICK & VAC			39	1	0	0		7,660	7,660 P.T. SUPPL	1,318
7450			HOME HEALTH EXPENSES			39	3	0	0		7,710	7,710 SOCIAL SE	22,225
7510			ACTIVITES WAGES	50,983	53,584	11	1	0	0		7,720	7,720 SOCIAL SE	1,716
7540			ACTIVITIES SICK & VAC	2,601		11	1	0	0		7,730		
7590			ACTIVITIES SUPPLIES	1,484	1,484	11	2	0	0		7,740	7,740 OCCUPAT	90,352
7595			ACTIVITIES FEES	0	0	11	3	0	0		7,750		
7610			PT WAGES			39	1	0	0		7,770	7,770 SPEECH TI	21,065
7611			PT SICK & VACATION			39	1	0	0		7,820	7,820 BEAUTICI	32
7620			PT FEES	98,406		39	3	0	-10,875 ***		7,890	7,890 BEAUTY S	443
7660			PT SUPPLIES	1,318		39	2	0	0		7,960		
7710			SOCIAL SERVICE WAGES	22,225	23,941	12	1	0	0		8,120	8,120 INTEREST	111,139
7720			SOCIAL SERVICE SICK & VAC	1,716		12	1	0	0		8,125	8,125 ALLOCAT	15,110
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		8,130	8,130 DEPRECIA	113,347
7740			OT FEE	90,352		39	3	0	-8,900 ***		8,150	8,150 LOAN FEE	6,060
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		9,510	9,510 INTEREST	(696)
7770			SPEECH THERAPY FEE	21,065		39	3	0	8,279 ***		9,520		
7800			BEAUTICIAN WAGES	8,432	8,432	40	1	0	0		9,530		
7810			BEAUTICIAN SICK & VAC	0		40	1	0	0			4,360 UTILIZATI	3,750
7820			BEAUTICIAN FEES	32	32	40	3	0	0			7,595 ACTIVITIE	0
7890			BEAUTY SHOP SUPPLIES	443	443	40	2	0	0			7,910 VOLUNTEER COORD-SALARY	
7910			VOLUNTEER COORDINATOR	0		21	1	0	0			7,940 VOLUNTEER COORD-VAC/SICK	
7940			VOL COORD SICK & VAC	0		21	1	0	0			7,960 VOLUNTEER COORD EXP	
7960			VOL COORD SUPPLIES	0		21	2	0	0			7,800 BEAUTICI	8,432
8100			RENT		0	34	3	0	0			7,820 BEAUTICI	0
8120			INTEREST EXPENSE	126,249	132,309	32	3	14	-696			4,361 OTHER PH	4,800
8130			DEPRECIATION	113,347	113,347	30	3	9	0				(58,449)
8150			LOAN FEE AMORTIZATION	6,060		32	3	0	0	60,773			
9510			INTEREST INCOME	-696		32	0	10	0				
9520			MISC NON-OPERATING INCOM	0		0	0	0	0				
9700			INCOME TAXES	0		0	0	0	0				
				3,450,735	3,451,431								
					696								
GRAND TOTALS				-58,449					-23,250				
				(NET INCOME)									
				0									
			FACILITY NAME:										
			FACILITY ID:	0									
			FACILITY UNITS:	89									
			BALANCE SHEET TOTAL	0									
				173,113									

	G/L	RECAP CENSUS
PP	8,846	8,713
IPA	16,606	16,606
medicare	3,416	3,416
		28,735
IPA BEDHOLDS	0	
PP BEDHOLDS	133	
PP CONVERS	0	